Exhibit 1

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

CAREMARK THERAPEUTIC SERVICES,	:	
Plaintiff,	:	
v.	:	Civil Action No. 05-Civ-00728
	:	ECF Case
MICHAEL O. LEAVITT, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES,	:	**DECLARATION OF RACHEL H. PARK**
Defendants.	:	

Rachel H. Park, pursuant to 28 U.S.C. § 1746, declares under penalty of perjury as follows:

1. I am an Assistant Regional Counsel for the United States Department of Health and Human Services, an executive agency of the United States of America (the "Government"). I am familiar with this matter and all the facts stated herein. I make this declaration in support of the Government's motion to dismiss plaintiff's complaint for improper venue and lack of subject matter jurisdiction.

2. Attached hereto as Exhibit A is a true and correct copy of Plaintiff Caremark Therapeutic Services' Federal Health Care Provider/Supplier Enrollment Application ("the Application"), dated October 28, 2004. The Application states that plaintiff is incorporated in California. Exh. A, at 9. The Application states that Medicare can contact the supplier at an address in Los Angeles, California, and lists plaintiff's practice location as Redlands, California. Exh. A, at 11, 17. The Application also states that Caremark RX, Inc., and Caremark International, Inc., owners with managing control of Caremark Therapeutic Services, are located

in Nashville Tennessee, and Northbrook, Illinois, respectively. Exh. A, at 25. In addition an excerpt from Caremark's website, www.caremark.com, which is attached hereto as Exhibit B, contains a list of Caremark's campus locations. According to this list, none of Caremark's locations are in New York.

Dated: New York, New York
April 21, 2005

RACHEL H. PARK

EXHIBIT A

OMB Approval No. 0938-0685

MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Suppliers that will Bill Medicare Carriers

General Instructions

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare & Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care suppliers, and that the amounts of the payments are correct. This information will also identify whether the supplier is qualified to render health care services to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the supplier that is seeking billing privileges in the Medicare program. If enrolling in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) do not complete this application. DMEPOS suppliers should contact the National Supplier Clearinghouse (NSC) at 803-754-3951 to obtain a CMS 855S for Medicare enrollment.

Medicare needs to know: (1) the type of health care supplier enrolling, (2) what qualifies this supplier to furnish health care related services, (3) where and how this supplier intends to render these services, and (4) those persons or entities with an ownership interest, or managerial control, as defined in this application, over the supplier.

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this supplier, check (√) the appropriate box in that section and skip to the next section. Sections 7, 11, and 12 have been deliberately omitted from this application because they are not applicable to the enrollment of suppliers that bill Medicare carriers.

1. General Application Information

This section is to be completed with general information as to why this application is being submitted and whether this supplier currently has a business relationship with Medicare or any another Federal health care program.
To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

A. Reason for Submittal of this Application

1. Check one: ☐ Initial Enrollment ☐ Reactivation

☒ Change of Information (Check appropriate Section(s) below and furnish this supplier's Medicare Identification Number here): FP0591796

☒ 1 ☒ 2 ☒ 3 ☒ 4 ☒ 5 ☒ 6 ☐ 8 ☐ 9 ☐ 10 ☒ 13 ☒ 15 ☒ 16
Attachment 1 - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Attachment 2 - ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Voluntary Termination of Billing Number—Effective Date (MM/DD/YYYY): _____

☐ Change of Ownership (Hospitals, Portable X-Ray Facilities, and Ambulatory Surgical Centers) - **Only**

2. Tax Identification Number: [redacted]

3. Is this supplier currently enrolled in the Medicare program? ☒ YES ☐ NO
IF YES, furnish the following information about the current carrier:

Current Carrier Name: NHIC Current Medicare Identification Number: FP0591796

REDACTED

OMB Approval No. 0938-068

2. Supplier Identification

This section is to be completed with information specifically related to the supplier submitting this application. Furnish the following information about the supplier: (1) supplier type, (2) supplier name, and (3) the mailing address and telephone number where Medicare can contact the supplier directly.

A. Type of Supplier ☐ Change **Effective Date:** _____

The supplier must meet all Medicare requirements for the type of supplier checked below. If this supplier is a single specialty clinic/group practice, the specialty must be reported. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Supplier (Check one):

- ☐ Ambulance Service Supplier
- ☐ Ambulatory Surgical Center
- ☐ Diagnostic Radiology Group Practice/Clinic
- ☐ Hospital Department(s), Hospital Outpatient Location(s) and/or Hospital Clinic(s) (complete # 4 below)
- ☐ Independent Clinical Laboratory (CLIA)
- ☐ Independent Diagnostic Testing Facility (IDTF)
- ☐ Mammography Screening Center
- ☐ Managed Care Plan (non-Medicare +Choice)
- ☐ Mass Immunization Roster Biller Only
- ☐ Medicare +Choice Organization
- ☐ Medical Faculty Practice Plan:
  See instructions for specific documentation requirements
- ☐ Multi-Specialty Clinic or Group Practice
- ☐ Occupational Therapy Group (complete # 2 below)
- ☐ Other Medical Care Group
- ☐ Physical Therapy Group (complete # 2 below)
- ☐ Physiotherapy Group
- ☐ Portable X-ray Facility
- ☐ Public Health/Welfare Agency
- ☐ Voluntary Health/Charitable Agency
- ☐ *Single-Specialty Clinic/Group Practice:
  *Specify group/clinic specialty below:
  _____
- ☒ Other (Specify): Pharmacy

2. PT/OT Groups ONLY - All occupational and physical therapy groups must answer the following questions:

a) Are all of the group's PT/OT services only rendered in patients' homes? ☐ YES ☐ NO
b) Does this group maintain private office space? ☐ YES ☐ NO
c) Does this group own, lease, or rent its private office space? ☐ YES ☐ NO
d) Is this private office space used exclusively for the group's private practice? ☐ YES ☐ NO
e) Does this group furnish PT/OT services outside of its office and/or patients' homes? ☐ YES ☐ NO
IF YES, provide a copy of the lease agreement which gives the group exclusive use of the facility for PT/OT services.

3. Will this supplier be receiving reassigned benefits from individual practitioners? ☐ YES ☒ NO
IF YES, submit a CMS 855R for each individual practitioner who will be reassigning benefits to this supplier.

4. Hospitals Only - If this supplier is a hospital applying for a billing number(s) for Part B practitioner services, check the appropriate box below. See instructions before completing this section.

☐ Single billing number for all departments ☐ Separate billing number for each department listed below

N/A		

B. Supplier Identification Information ☐ Change **Effective Date:** _____

Furnish the supplier's legal business name (as reported to the IRS), "doing business as" name (name supplier generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation.

1. Legal Business Name as Reported to the IRS Caremark, Inc.	Date Business Started (MM/DD/YYYY) 06/12/1979
2. "Doing Business As" (DBA) Name (if applicable) *Caremark (Federally Registered Trademark)*	County/Parish where DBA Name Registered (if applicable) *N/A*
3. Identify the type of organizational structure for this supplier (Check one): ☒ Corporation ☐ Partnership ☐ Other (Specify): _____	
4. Incorporation Date (if applicable) (MM/DD/YYYY) 06/12/1979	State where Incorporated (if applicable) California

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2. Supplier Identification (Continued)

C. Correspondence Address ☐ Change **Effective Date:**

This must be an address and telephone number where Medicare can contact this supplier directly.

Mailing Address Line 1: Dept. 6175

Mailing Address Line 2:

City	State	ZIP Code + 4
Los Angeles	CA	90088-6175

Telephone Number	(Ext.)	Fax Number (if applicable)	E-mail Address (if applicable)
(800) 225-5967	( )	(909) 799-4364	

D. Accreditation (Ambulatory Surgical Centers (ASCs) ONLY) ☐ Change **Effective Date:**

1. Is this supplier accredited? N/A ☐ YES ☐ NO ☐ PENDING
   IF YES, complete the following:
2. Date of Accreditation (MM/DD/YYYY):
3. Name of Accrediting Body:

E. Comments

Explain any unique or unusual circumstances concerning the supplier's practice location(s), the method by which the supplier renders health care services, or any special billing number requirements.

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3. Adverse Legal Actions and Overpayments

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have l imposed or levied against this supplier (see Table A below for list of adverse actions that must be reported).

A. Adverse Legal History ☐ Change **Effective Date:**_____

1. Has this supplier, under any current or former name or business identity, ever had any of the adverse legal act listed in Table A below imposed against it? ☒ YES ☐ N
2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
PLEASE SEE ATTACHED OIG STATEMENT			

Table A

1) Any felony or misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service un Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a he care item or service.

2) Any felony or misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

3) Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of i investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

4) Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distributi prescription, or dispensing of a controlled substance.

5) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

6) Any revocation or suspension of accreditation.

7) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care progra or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

8) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information ☐ Change **Effective Date:**_____

1. Does this supplier, under any current or former name or business identity, have any outstanding Medica overpayments? ☐ YES ☒ NO *
2. IF YES, furnish the name and account number under which the overpayment(s) exists.

Name under which the overpayment occurred:	Account number under which the overpayment exists:
*OTHER THEN ROUTINE REFUNDS MADE IN THE NORMAL	COURSE OF BUSINESS

OMB Approval No. 0938

4. Current Practice Location(s)

This section is to be completed with information about the physical location(s) where this supplier currently renders he care services. If this supplier operates a mobile facility or portable units, furnish the address for the "Base of Operatic as well as vehicle information and the geographic area served by these facilities or units. In addition, cite where supplier wants its payments sent, and where the supplier maintains patients' medical records. If there is more than practice location, copy and complete this section for each.

A. Practice Location Information ☐ Add ☐ Delete ☐ Change **Effective Date:** 08/01/1993

1. Practice Location Name	Date Started at this Location (MM/DD/YYYY)
Caremark, Inc.	

2. Practice Location Address Line 1: 1127 Bryn Mawr Avenue

Practice Location Address Line 2:

City	County/Parish	State	ZIP Code + 4
Redlands	San Bernardino	CA	92374-4558

Telephone Number	(Ext.)	Fax Number (if applicable)	E-mail Address (if applicable)
(909) 796-7171	( )	(800) 976-8717	

3. Does this supplier own/lease this practice location? ☒ YES ☐ NO

4. Is this practice location a:
- hospital? ☐ YES ☒ NO
- retirement/assisted living community? ☐ YES ☒ NO
- group practice office/clinic ☐ YES ☒ NO
- other health care facility? (Specify): Pharmacy ☒ YES ☐ NO

5. CLIA Number for this location (if applicable)	FDA/Radiology (Mammography) Certification Number(s) for this location (if applicable)
N/A	N/A

B. Mobile Facility and/or Portable Units ☐ Change N/A **Effective Date:**

Does this supplier furnish health care services from a mobile facility or portable unit? ☐ YES ☒ NO
IF YES, use Sections 4C through 4E to furnish information about the mobile/portable services.
IF NO, proceed to Section 4F (Medicare Payment "Pay To" Address).

C. Base of Operations Address ☐ Add ☐ Delete ☐ Change **Effective Date:**

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is storec and, when applicable, where vehicles are parked when not in use. See instructions for further examples.
Check here ☐ and skip to Section 4D if the "Base of Operations" address is the same as the "Practice Location."

1. Base of Operations Name N/A	Date Started at this Location (MM/DD/YYYY)

2. Street Address Line 1:

Street Address Line 2:

City	County/Parish	State	ZIP Code + 4

Telephone Number	(Ext.)	Fax Number (if applicable)	E-mail Address (if applicable)
( )	( )	( )	

D. Vehicle Information ☐ Add ☐ Delete ☐ Change **Effective Date:**

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. See the instructions for a full explanation of the types of vehicles that need to be reported. If more than three vehicles are used, copy and complete this section as needed.

1. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
N/A	
2. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
3. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number

Note: For each vehicle, a copy of all health care related permits/licenses/registrations MUST be submitted.

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4. Practice Location (Continued)

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services

N/A ☐ Add ☐ Delete **Effective Date:**_____

Furnish the county/parish, city, State and ZIP Code for all locations where mobile and/or portable services are rendered.

Note: If this supplier renders mobile health care services in more than one State, and those States are served by different Medicare contractors, a separate CMS 855B enrollment application must be completed for each Medica contractor jurisdiction.

1. Initial Reporting and/or Additions:

N/A

County/Parish:	City:	State:	ZIP Code(s):

2. Deletions:

N/A

County/Parish:	City:	State:	ZIP Code(s):

F. Medicare Payment "Pay To" Address ☐ **Change** **Effective Date:**_____

Furnish the address where payment should be sent for services rendered at the practice location(s) in Section 4A or 4C.

"Pay To" Address Line 1 Dept. 6175

"Pay To" Address Line 2

City	State	ZIP Code + 4
Los Angeles	CA	90088-6175

Check here ☐ and complete and submit Form HCFA-588 with this application if the supplier would like its payments electronically transferred to its bank account.

G. Location of Patients' Medical Records ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check here ☒ if all patients' medical records are stored at the location shown in Section 4A or 4C, and skip this section.
2. If any of the patients' medical records are stored at a location other than the location shown in Section 4A or 4C, complete this section with the name and address of the storage location.

Name of Storage Facility/Location

Storage Facility Address Line 1

Storage Facility Address Line 2

City	State	ZIP Code + 4

H. Comments

Explain any unique or unusual circumstances concerning the supplier's practice location(s) or the method by which the supplier renders health care services.

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5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) owners interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2B, as well as information on adverse legal actions that have been imposed against that organization. See instructions for examples organizations that should be reported here. If there is more than one organization, copy and complete this section for eac

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**

1. Check all that apply: ☒ 5% or more Ownership Interest ☒ Managing Control ☐ Partner		Effective Date of Ownership (MM/DD/YYYY)
2. Legal Business Name: CAREMARK RX, INC.		Effective Date of Control (MM/DD/YYYY) 11/29/1995
3. "Doing Business As" Name (if applicable)		Tax Identification Number [redacted]
4. Business Address Line 1: 211 COMMERCE ST.		Medicare Identification Number(s) (if applicable)
Business Address Line 2: SUITE 800		
City: NASHVILLE	State: TN	ZIP Code + 4: 37201-1817

C. Adverse Legal History ☐ Change ☐ **Effective Date:**

This section is to be completed only if the organization in Section 5B above is a 5% or greater owner (direct or indirect) of the supplier identified in Section 2B, or has a partnership interest in the supplier identified in Section 2B.

1. Has the organization in Section 5B above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against it? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-068

5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2B, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change Effective Date:_____

1. Check all that apply: ☒ 5% or more Ownership Interest ☒ Managing Control ☐ Partner	Effective Date of Ownership (MM/DD/YYYY)
2. Legal Business Name: CAREMARK INTERNATIONAL, INC.	Effective Date of Control (MM/DD/YYYY) 08/07/1992
3. "Doing Business As" Name (if applicable)	Tax Identification Number [redacted]
4. Business Address Line 1: 2211 SANDERS RD.	Medicare Identification Number(s) (if applicable)
Business Address Line 2	
City: NORTHBROOK / State: IL / ZIP Code + 4: 60062-6150	

C. Adverse Legal History ☐ Change ☐ Effective Date:_____

This section is to be completed only if the organization in Section 5B above is a 5% or greater owner (direct or indirect) of the supplier identified in Section 2B, or has a partnership interest in the supplier identified in Section 2B.

1. Has the organization in Section 5B above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against it? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-061

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
Sandy	L.	Campa	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) 08/04/1994	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☐ Director/Officer ☒ Other (Specify): Delegated Official

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
   Legal Business Name of Organization: _____

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☐ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 09

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) own interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and mar employees of the supplier must also be reported in this section. In addition, any information on adverse legal action have been imposed against the individuals reported in this section must be furnished. If there is more than one indiv copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
WILLIAM	ROBERT	KOSCH	NA

Social Security Number	Date of Birth (MM/DD/YYYY)	Credentials (M.D. O.D., etc.)
[redacted]	[redacted]	R. Ph.

Medicare Identification Number (if applicable)	Effective Date of Ownership (MM/DD/YYYY)	Effective Date of Control (MM/DD/YYYY)
		08/21/20

2. If the above individual is directly associated with the supplier in Section 2B, what is this individual's relationship the supplier? (Check all that apply.)
   ☐ 5% or Greater Owner ☐ Partner ☒ Managing Employee
   ☐ Director/Officer ☐ Other (Specify): Pharmacist in Charge

3. If the above individual is directly associated with an organization identified in Section 5B, furnish the name of organization in the space below:
   Legal Business Name of Organization: _____

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☐ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if t individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an acti employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body th imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

OMB Approval No. 0938-068

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
BRADLEY	S.	KARRO	N/A
Social Security Number [redacted]		Date of Birth (MM/DD/YYYY) [redacted]	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) 03/24/2004 ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)

☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATES OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC. AND CAREMARK INTERNATIONAL INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?

☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

OMB Approval No. 0938-0685

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
EDWIN	McCALL	CRAWFORD	N/A
Social Security Number [redacted]		Date of Birth (MM/DD/YYYY) [redacted]	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A		Effective Date of Control (MM/DD/YYYY) ***

2. If the above individual is directly associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

3. If the above individual is directly associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ **Effective Date:** _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-06

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
EDWARD	L.	HARDIN	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
JOHN	DAVID	JOYNER	N/A
Social Security Number [redacted]		Date of Birth (MM/DD/YYYY) [redacted]	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A		Effective Date of Control (MM/DD/YYYY) ***

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ **Effective Date:** _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-06

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
KIRK		McCONNELL	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify):_____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATES OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC. AND CAREMARK INTERNATIONAL INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ **Effective Date:**_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-068

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
HOWARD	A.	McLURE	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) 03/24/2004 ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☒ Director/Officer ☐ Other (Specify):_____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATES OF CONTROL
   Legal Business Name of Organization: CAREMARK RX, INC AND CAREMARK INTERNATIONAL INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ **Effective Date:**_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-0685

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
RUDY		MLADENOVIC	N/A
Social Security Number [redacted]		Date of Birth (MM/DD/YYYY) [redacted]	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) 03/24/2004 ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):_____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
Legal Business Name of Organization: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ Effective Date:_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-06

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
DIANE	B.	NOBLES	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify):_____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATES OF CONTROL.
Legal Business Name of Organization: CAREMARK RX, INC. AND CAREMARK INTERNATIONAL INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ Effective Date:_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-06

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownershi interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managin employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions tha have been imposed against the individuals reported in this section must be furnished. If there is more than one individual copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
RICHARD	P.	SCARDINA	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	

Medicare Identification Number (if applicable)	Effective Date of Ownership (MM/DD/YYYY)	Effective Date of Control (MM/DD/YYYY)
N/A	N/A	*** 03/01/1998

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☒ Director/Officer ☐ Other (Specify):_____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
   Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ Effective Date:_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-068

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
PETER	J.	CLEMENS	IV
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ **Effective Date:** _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-068

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
SARA	J.	FINLEY	N/A
Social Security Number [redacted]		Date of Birth (MM/DD/YYYY) [redacted]	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY)	*** 09/10/1998

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):_____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
Legal Business Name of Organization: ***SEE ATTACHED FOR EFFECTIVE DATES OF CONTROL CAREMARK RX, INC. AND CAREMARK INTERNATIONAL INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ Effective Date:_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-068

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
DAVID	W.	GOLDING	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	

Medicare Identification Number (if applicable)	Effective Date of Ownership (MM/DD/YYYY)	Effective Date of Control (MM/DD/YYYY)
N/A	N/A	*** 01/01/1998

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)

☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL

Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?

☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-0685

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
MARK	S.	WEEKS	N/A
Social Security Number [redacted]		Date of Birth (MM/DD/YYYY) [redacted]	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

OMB Approval No. 0938-06

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
CONSTANCE	M.	ISLEY	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) 05/29/2001	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
Legal Business Name of Organization: _____

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-068

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
GEORGE		PAVLAKIS	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) 05/28/2000	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☐ Director/Officer ☒ Other (Specify): DELEGATED OFFICIAL

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
   Legal Business Name of Organization: _____

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☐ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ **Effective Date:** _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED

OMB Approval No. 0938-0685

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
EDWIN	M.	BANKS	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
Legal Business Name of Organization: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

OMB Approval No. 0938-06

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**

1. Name First	Middle	Last	Jr., Sr., etc.
C.	DAVID	BROWN	II
Social Security Number [redacted]		Date of Birth (MM/DD/YYYY) [redacted]	Credentials (M.D., O.D., etc.) N/A
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A		Effective Date of Control (MM/DD/YYYY) ***

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify):

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:
Legal Business Name of Organization: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):

B. Adverse Legal History ☐ Change ☐ Effective Date:

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

OMB Approval No. 0938-0685

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
COLLEEN		CONWAY-WELCH	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) Ph.D.
[redacted]		[redacted]	

Medicare Identification Number (if applicable)	Effective Date of Ownership (MM/DD/YYYY)	Effective Date of Control (MM/DD/YYYY)
N/A	N/A	***

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify):_____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ Effective Date:_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

OMB Approval No. 0938-0685

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name First	Middle	Last	Jr., Sr., etc.
HARRIS		DIAMOND	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	
Medicare Identification Number (if applicable) N/A	Effective Date of Ownership (MM/DD/YYYY) N/A	Effective Date of Control (MM/DD/YYYY) ***	

2. If the above individual is **directly** associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): _____

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☒ Director/Officer ☐ Other (Specify): _____

B. Adverse Legal History ☐ Change ☐ Effective Date: _____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

OMB Approval No. 0938-0685

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
KRISTEN		GIBNEY-WILLIAMS	N/A
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.) N/A
[redacted]		[redacted]	

Medicare Identification Number (if applicable)	Effective Date of Ownership (MM/DD/YYYY)	Effective Date of Control (MM/DD/YYYY)
N/A	N/A	***

2. If the above individual is directly associated with the supplier in Section 2B, what is this individual's relationship with the supplier? (Check all that apply.)
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☐ Director/Officer ☐ Other (Specify):_____

3. If the above individual is directly associated with an organization identified in Section 5B, furnish the name of that organization in the space below: ***SEE ATTACHED FOR EFFECTIVE DATE OF CONTROL
   Legal Business Name of Organization: CAREMARK RX, INC.

4. What is this individual's role with the organization reported in Section 6A3 above (check all that apply)?
   ☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
   ☒ Director/Officer ☐ Other (Specify):_____

B. Adverse Legal History ☐ Change ☐ Effective Date:_____

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☒ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
N/A			

REDACTED